

Partners for Health Reform *Plus*

Jordan Assessment Team Report
(Draft Document)

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1. Project Background

The PHR and PHR*plus* projects have been providing Technical Assistance to the MOH and the Government of Jordan, since March 1998. The PHR*plus* project formally began with the acceptance, in May 2001, of the Jordan Country Assistance Plan (CAP), by the USAID Jordan Mission. Year 4 budgetary allocations for the PHR*plus* project amount to \$1.5 million. This is the total amount allocated across all project activities. As designed, the project focus on three major areas:

- **Health Insurance Technical Assistance (Health Insurance Pilot Project, HIPP):** The focus of PHR*plus* in this area of technical assistance is to strengthen the contracting strategies of the Civil Insurance Program (CIP). This will enable the CIP to act as an effective purchasing agent for CIP beneficiaries. The initial focus of the contracting is in the area of maternal health services, specifically delivery including pre and postnatal care. By defining a service bundle that includes essential pre and postnatal services with inpatient deliveries, the CIP program assures both continuity of care and compliance with contract requirement. Because both pre and postnatal care will be included in the service bundle essential maternal health service will be delivered by the contracted providers and monitored by the CIP, as a condition of the contract. In section 3 of this document, we discuss the accomplishment thus far under the HIPP, and the Assessment Team's proposal for expanding PHR*plus* health insurance TA, within the framework of the new Mission Strategy for 2004-2009.
- **Hospital Decentralization Technical Assistance:** The overall objectives of the hospital decentralization activity are to improve the operating efficiency of MOH hospitals. The governance of MOH hospitals is highly centralized. All significant managerial, budgetary, and procurement matters are ultimately determined by senior-level executives at the MOH headquarters in Amman. This has created a system in which the needs of hospitals and their patients frequently conflict with the policies of the central ministry. As a result, PHR*plus* has continued its decentralization efforts at Princess Raya and Al Karak, and have expanded these efforts to include two additional institutions, Al Nadeem and Jerash hospitals. In section 4 of this document, we discuss the accomplishments thus far under the PHR*plus* hospital decentralization effort, and the Assessment Team's proposal for expanding this activity, within the framework of the new Mission Strategy for 2004-2009.
- **National Health Accounts (NHA) Technical Assistance:** The focus of PHR*plus* TA in the area of National Health Accounts has been the institutionalization of the effort within the MOH. In addition, PHR*plus* has been instrumental in assisting the MOH in its data gathering efforts and in the production of its recent 2000 and 2001 estimates. In section 5 of this document, we discuss the accomplishment thus far under the PHR*plus* NHA effort, and the Assessment Team's proposal for this activity, within the framework of the New Mission Strategy.

2. Background and Objectives of PHR*plus* Assessment

In 2003, USAID/Jordan developed a new assistance strategy for Jordan, which redefined the mission's strategic objectives for the period 2004-2008. This strategy was developed and agreed to as a result of a process outlined below:

- Feb 2003: Team evaluates USAID Jordan's population and health programs,
- Aug 2003: USAID Jordan concept paper produced, "Gateway to the Future",
- Oct 2003: USAID, MOH and other sectors develop a "Strategic Framework" for Jordan,
- Oct 2003: Two-day workshop to develop approaches to the Strategic Framework,
- Nov-Dec 2003: Complete strategy is developed for Jordan ("**Improved Health Status for All Jordanians**"),
- Jan-Sep 2004: First year of implementing new strategy

USAID/Jordan requested a PHR*plus* team to travel to Jordan to assess how its current program might be amended in light of the Mission's new strategy. The team was asked to meet with stakeholders in the Ministry of Health and with other representatives of the health sector to assess whether to retain, modify or eliminate aspects of the current PHR*plus* Country Activity Plan; and, to recommend additional new activities that would help the Jordan health sector move rapidly toward achieving the goals outlined in the new strategic framework.

The assessment team focused on SR 2 "Improved Health Sector Policies and Public Health Systems," which includes 9 approaches (see attached Strategic Framework and Nine Approaches for SR2, Appendix 1). All PHR*plus* past, current and recommended new activities fall within SR 2. Below we highlight nine the approaches to SR2, and PHR*plus*' contributions in each area:

- **Promote partnerships between sectors**
 - ✓ PHR*plus* Health Insurance Pilot Project (HIPP)
- **Human resource development**
 - ✓ Formal training of MOH and other personnel
 - ✓ Extensive on-the-job training of MOH personnel
 - ✓ The development of job descriptions for hospital-based personnel
- **Upgrade performance standards**
 - ✓ Obstetric and Newborn clinical practice guidelines (HIPP)
 - ✓ Promotion of policy dialogue on hospital accreditation
- **Rationalization of primary, secondary and tertiary health care**
 - ✓ PHR*plus* hospital decentralization activity
- **Health insurance reform**
 - ✓ Improving private sector contractual procedures of MOH, (HIPP)

- **Institute effective cost-containment strategies**
 - ✓ Institutionalize National Health Accounts (NHA)
 - ✓ Provide technical support to Health Economics Directorate
 - ✓ Conducted graduate level course in Health Care Economics
- **Quality data-gathering, dissemination and use**
 - ✓ PC-based Health Information System for HIPP
 - ✓ Ongoing surveys, focus groups, and data compilation
- **Enact/revise legislation to promote improved health status**
 - ✓ No PHR*plus* activities in this area, thus far
- **Encourage community participation**
 - ✓ The designing and nomination of "Boards of Directors" at Al Karak and Princess Raya hospitals

PHR*plus* proposed an Assessment Team consisting of the following individuals:

- Nancy Pielemeier, DrPH, PHR*plus* Project Director and Team Leader – health policy and planning
- Dwayne Banks, PhD, PHR*plus* Chief of Party in Jordan, Team Member – health financing and economics
- Alan Fairbank, PhD, PHR*plus* Senior Technical Advisor, Team Member – health economics and health insurance
- Lonna Milburn, PhD, PHR*plus* Senior Technical Advisor, Team Member – health services and management

The Assessment Teams' scope of work is attached as Appendix 2.

The Team arrived in country on 14 February 2004 and departed on 24 February 2004. Unfortunately, Dr. Fairbank was ill and unable to travel to Jordan at the last minute, so the assessment was completed by the other team members.

Prior to the external team members' arrival, the PHR*plus*/Jordan staff briefed policy-makers on the objectives of the visit and set up a schedule of interviews, as well as a panel discussion meeting of MOH stakeholders. The schedule of interviews conducted by the assessment team, as well as the agenda and list of attendees at the panel discussion held on 19 February 2004, are attached (Appendix C). The team also visited Al Karak hospital and was briefed on the ongoing joint MOH-PHR*plus* hospital decentralization activity.

General Conclusions of the Assessment Team

The team observed the mounting pressures on the health sector in Jordan, resulting from the following forces, among others:

- Increased political pressures for expanding access to the estimated 40 percent of the population that is uninsured (roughly 1.9 million persons),
- Increased expectations of the population, with respect to access to health care services

- Ever expanding opportunities for health care professionals within and outside of Jordan, due to an expanding private sector market place, and significant opportunities abroad (most notably in the Gulf states),
- The growth of the health care market, especially in the hospital sector,
- The mounting costs of health care inputs (e.g., pharmaceuticals, diagnostic and therapeutic devices),
- The increased burden of chronic diseases, due to the aging of the population.

As a result of these forces, several central themes emerged from the stakeholder discussions, which form the basis of this report. The themes that fit within the capabilities of *PHRplus* include Health Insurance Reform, Hospital Decentralization, Hospital Accreditation, National Health Accounts, and Cost Containment Strategies.

The Team also observed the need for a new underlying concept for capacity building in the Jordanian health sector. The Assessment Team concluded that a great deal of capacity has been built in health systems, finance, management and economics over the course of the past 6 years, as a result of many inputs, including those of the PHR and *PHRplus* projects. This increased capacity has contributed to the new awareness of the need for intervention into the health care system, as described above. It was also clear to the Assessment Team that Jordanian stakeholders are more eager than ever to build local capacity to address the challenges of the health system on an ongoing basis. In order to build sustained capacity of Jordanian health sector institutions to deal with existing and future realities, it will be critically important for USAID through *PHRplus* and follow-on projects to focus on **institutional** capacity building.

While building of institutional capacity clearly requires building the capacity of individuals, the Team believes that the focus must shift from providing training for individuals, to broad-based capacity development. This means that support for training should shift from general types of training catering to the desire for individual professional development, to on-the-job “just in time” training which will enable *PHRplus* counterparts to follow each step in the process of data collection, analysis, program and policy development. This subtle shift in philosophy is important to building the capacity of institutional counterparts, to carry on the health policy and systems work at the end of the USAID 5-year strategy period. Finally, the Assessment Team concluded that it is important for *PHRplus* to position itself such that it is able to work with a variety of organizations, such as the Higher Health Council (Technical Secretariat) and Health Insurance Directorate on a regular basis. This would serve to facilitate the level of “institutional” capacity building that is needed under a revised *PHRplus* scope of work. In this document we have specified the relevant counterpart institutions that would best facilitate the implementation of various components of the project.

In Table 1 we summarize current and planned *PHRplus* activities relative to the nine approaches that are outlined in the New Mission Strategy for 2004-2009. In addition to indicating *PHRplus* activities in each area, Table 1 also includes the level of intervention (i.e., none, minimal, moderate and high) that *PHRplus* currently provides or anticipates providing during the 2004-2009 period.

Table 1: PHR*plus* current and planned activities, relative to New Mission Strategy for 2004-2009 period.

The Nine Approaches to SR2	Current PHR <i>plus</i> Activity in Area	Level of Intervention (none,minimal,moderate,high)	Counterpart Institution
1. <i>Promote partnerships between sectors</i> a. Include all sectors (public, NGO, commercial) b. Activate Higher Health Council	Current/planned activity , a primary focus of the Health Insurance Pilot Project (HIPP) Planned activity	High level of intervention High level of intervention	Health Insurance Directorate (HID) Higher Health Council (HHC)
2. <i>Human resource development</i> a. Manpower/management training b. Job descriptions c. Continuing medical education d. Performance-based incentives e. Recruiting and affirmative action policies for women/underserved	Current/planned activity , training of MOH personnel in management, finance, computers, English Current activity No planned activities Planned activity No planned activities	High level of intervention High level of intervention No current or planned intervention Moderate level of intervention No current or planned intervention	HHC, HID, MOH HHC, MOH MOH (Personnel Division)
3. <i>Upgrade performance standards</i> a. Accreditation b. Licensing c. Review/update guidelines/protocols	Planned activity for program in hospital accreditation Planned activity for program in hospital accreditation Current/planned activity in HIPP, and hospital accreditation	High level of intervention Moderate level of intervention High level of intervention	HHC, Al Bashir HHC, MOH HHC, HID, MOH

4. <i>Rationalization of primary, secondary and tertiary health care</i>	Planned activity for integrating the referral process between pilot hospitals and clinics	High level of intervention, under cost-containment activity	MOH, HID, HHC
a. Integration of primary, secondary levels, including referrals			
b. Decentralization in public health sector	Current/planned activity under the Hospital Decentralization	High level/moderate level after September 2004	MOH
c. Promotion of family medicine/GP approach and comprehensive PHC	No planned activities	No intervention	

Table 1 (continued): PHR*plus* current and planned activities, relative to New Mission Strategy for 2004-2009 period.

The Nine Approaches to SR2	Current and Planned PHR<i>plus</i> Activity in Area	Level of Intervention (none,minimal,moderate,high)	Counterpart Institution
5. Health Insurance reform a. Effective strategy to deal with the uninsured b. Improve contractual procedures with private sector c. Expand benefits to cover expanded package of services	Current/planned activity Current/planned activity No planned activity	Moderate level of intervention High level of intervention No planned activities	HHC, HID HID No planned activities
6. Institute effective cost-containment strategy a. Institutionalize NHA b. Use health economics concepts in decision-making process c. Formulate financial sustainability policies d. Institute Certificate of Need (CON) policy e. Activate procurement system in public sector	Current/no planned activity Current/planned activity Planned activity for Health Insurance TA Planned activity No planned activity	High level/ minimal intervention after September 2004 High level of intervention High level of intervention High level of intervention No planned activity	HHC, HID HHC, HID, MOH HHC No planned activities
7. Quality data-gathering, dissemination and use a. Improve information systems b. Promote and expand automation and	Current activity under HIPP Current activity under HIPP	Moderate intervention Moderate intervention	HID HID

computerization			
c. Improve surveillance systems for infectious & chronic diseases	No planned intervention	No planned intervention	
d. Strengthen health research capability	Current/planned activity under several components of PHR <i>plus</i>	High level of intervention	HID, HHC

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Table 1 (continued): PHR*plus* current and planned activities, relative to New Mission Strategy for 2004-2009 period.

8. <i>Enact/revise legislation to promote improved health status</i>			
a. Improve operational policies	Planned activity under Health Insurance TA	Moderate level of intervention	HID, HHC, MOH
b. Deal with emerging health policy needs as they arise	Planned activity Under Health Insurance TA	No planned intervention	HID, HHC, MOH
9. <i>Encourage community participation</i>			
a. Community involvement in setting priorities and action implementation, especially for health lifestyle sub-result	No planned intervention	No planned intervention	
b. Establish "community advisory boards" for health care faculties	Current activity under Hospital Decentralization	Minimal intervention	MOH
c. Establish environment of volunteerism in health sector	No planned interventions	No planned intervention	

As illustrated in Table 1, the majority of the activities that are listed under the nine approaches to SR2 are classified as current PHR*plus* activities or planned PHR*plus* activities (as proposed in this Assessment Report). In addition, Table 1 describes the level of intervention to be undertaken by PHR*plus* (i.e., none, minimal, moderate or high) to achieve the relevant objectives under each of the nine approaches. The vast majority of interventions will require a high-level of intervention on the part of PHR*plus*. For those interventions that require: none, minimal, or moderate interventions, Table 2 provides the reader with a summary of the necessary policy recommendations for effectively addressing the level and type of interventions that might be required.

Table 2: Policy recommendations for addressing areas of technical assistance where PHR*plus* planned intervention is “moderate” or less.

Strategy Approach to SR2	PHR <i>plus</i> Intervention	Policy Recommendation for Increasing Intervention Level
2c. Continuing Medical Education	No planned intervention	CME should be integrated into the employee performance review process; incentives should be provided to nurses and other personnel for achieving targeted CME objectives. Some CME policy recommendations will be incorporated into the proposed hospital accreditation technical assistance. Projects such as PHCI are better suited for providing long-term technical assistance in this area.
2d. Performance-based incentives	Moderate intervention	Requires MOH implementation of existing recommendations, such as the PHR <i>plus</i> assisted document that outlines the implementation of a performance-based incentive plan for MOH employees.
2e. Recruiting and affirmative action policies for women/underserved	No planned intervention	The Ministry of Education working with the MOH should explore the possibility of establishing a program whereby categorical groups are provided with significant financial support and enrollment priorities into institutions of higher learning. A loan guarantee program can be implemented, whereby offsets to the loan may result for individuals choosing to work in underserved areas. Preference policies that currently exists for "categorical groups" of Jordanians should be explored, and revised to achieve targeted objectives.
3b. Licensing	Moderate intervention	The government currently has acceptable licensing rules for facilities and medical personnel. The hospital accreditation program that is being proposed will likely elucidate for the MOH those areas where additional licensing requirements might be considered.
4c. Promotion of the family medicine/GP approach and comprehensive PHC	No planned intervention	Would recommend promotion and implementation of such an objective through the PHCI or similar project. In addition, the implementation of effective model requires immense education of both the patient and provider of care. Other CAs, particular those with extensive experience in behavioral change communication may be a source the effective implementation of such a policy.
5a. Effective strategy to deal with uninsured	Moderate intervention	The design of an effective strategy to deal with the uninsured requires both technical and political support. PHR <i>plus</i> will be providing significant TA in this area (e.g., identifying the uninsured, estimating their utilization of services and expenditures) within the framework of its health insurance TA; however, the implementation of such a strategy requires consistent and focused political support at the highest levels of government.
5c. Expand benefits to cover expanded package of services	No planned intervention	The MOH currently provides a generous package of benefits to Civil Service employees, and other categorical groups, such as those with end-stage renal disease and cancer. The MOH has not expressed interest in expanding the existing package of benefits, just the opposite has been proposed: that of decreasing the level of benefits provided by increasing patient cost-sharing requirements, and through the implementation of an effective utilization review mechanism.

Table 2 (continued): Policy recommendations for addressing areas of technical assistance where *PHRplus* planned intervention is “moderate” or less.

6e. Activate procurement system in public sector	No planned intervention	An assessment of the MOH procurement system needs to be conducted prior to the implementation of a policy that can effectively deal with many of the issues discussed by some stakeholders. For example, the MOH procurement system for drugs, devices, and equipment is highly centralized. This leads to an inefficient allocation of these resources, if the needs of providers are not fully considered prior to the distribution of these resources to hospitals and clinics. Many of these issues have been discussed under the <i>PHRplus</i> hospital decentralization TA; however, little action has been taken by the MOH to change the existing system.
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3. Health Insurance Under New Strategy

Assessment Findings

PHR and PHR*plus* have provided technical assistance and capacity building, in the area of health insurance reform, to the government of Jordan (GOJ) and the Ministry of Health (MOH) since March 1998. Earlier activities focused primarily on data gathering efforts, in an attempt to identify uninsured populations, the incidence and scope of health insurance coverage in the public and private sectors, as well as the prevalence and economic behavior of third-party payers. Activity in each of the areas included, but was not limited to the following:

- Apr 1998: Convened a round-table discussion with the Minister of Health and other senior level public and private sector officials on establishing guidelines for implementing health insurance reform in Jordan (Feder and Fairbank, 1998),
 - Jun 1998: Conducted a survey of private sector third-party payers, and their roles in financing and administering health insurance in Jordan (Hollander and Rauch, 1998),
 - Nov 1998: Conducted a workshop to explore the issues and options that the government should consider when designing voluntary or compulsory health insurance in Jordan (Banks et al., 1998),
 - Jun 1999: Conducted focus groups on the uninsured and obtaining information on their willingness to purchase MOH sponsored voluntary health insurance (Banks et al., 1999).
 - Jun 1999 and Dec 2000: Developing a comprehensive profile of the uninsured in Jordan. This study highlighted the demographic and geographic distribution of the uninsured in Jordan (Banks et al., 2001),
 - Sep 1999: Conducted a survey of 500 private companies and their provision of health insurance to their employees, as well as an assessment of the willingness of uninsured workers to purchase MOH voluntary health insurance,
 - Dec 2000: Implemented and conducted the preliminary analysis of the Jordan Healthcare Utilization and Expenditure Survey 2000 (PHR 2000). This first-ever survey of health care utilization and expenditures, serves as the most comprehensive analysis of household utilization and expenditures in Jordan to date,
 - Nov and Dec 2003: PHR*plus* provided a five-week course in health care economics to MOH and other personnel. Personnel attending the course were from the MOH, Higher Health Council, and the private sector. The course consisted of 10 lectures,
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350 pages of selected health policy articles, and the latest and most popularly used textbook on health economics (Phelps, 2003).¹

Current PHR*plus* technical assistance in the area of health insurance reform focuses primarily upon improving the contracting abilities of the Health Insurance Directorate, with respect to private sector contracting. The Health Insurance Pilot Project (HIPP), as it is commonly referred to, is based upon designing optimal contracts and monitoring systems for a sample of 250 Civil Insurance Program (CIP) beneficiaries. Recent outcomes of such technical assistance includes the following:

- The establishment of a full functioning Implementation Unit (IU) within the Health Insurance Directorate. This IU serves as the focal point for all administrative claims processing for the HIPP,
- A PC-based health information system for tracking enrollees has been established. Personnel have received extensive training on the appropriate use of the system, for claims processing and monitoring of services provided to beneficiaries,
- Clinical practice guidelines for obstetric/gynecology and newborn care have been developed. These guidelines will assist selected hospitals in establish uniform treatment protocols for HIPP enrollees,
- A “patient’s rights pamphlet” has been developed with the assistance of Johns Hopkins CCP. This pamphlet will inform patients of their rights under the HIPP, such as the right to select a physician of their choice from a panel of eligible HIPP providers,
- A Request for Qualifications has recently been issued. Seventeen hospitals in Amman have responded to this RFQ by providing information about the clinical capabilities of their hospitals, as well as its organizational and managerial structure,
- A Request for Proposals (RFP) and bidder’s conference are scheduled to be released and implemented, respectively, no later than mid-April 2004.

The Assessment Team obtained information from several stakeholders about the current health insurance reform environment. The consensus among stakeholders is that the current policy environment, with respect to health insurance reform, is significantly different than that of previous period. The predominant view, from both the public and private sectors, is that political pressures make significant health insurance reform inevitable. An example of such reform, is the recent policy of expanding Civil Insurance Program (CIP) benefits to uninsured children under the age of six-years. Other policies, such as expanding CIP benefits to the spouses and dependents of female civil servants, and revisions to the “poverty index” could expand the current CIP beneficiaries by as much as 1.5 million persons.²

¹ Charles Phelps, *Health Economics*, 2003.

²Information obtained from conversations with Health Insurance Directorate personnel. Household's classified as “poor” are automatically eligible for full CIP benefits. Such households are often referred to as “green card” holders.

Stakeholders consistently expressed the need for analytical assistance to both the Health Insurance Directorate and the Higher Health Council. The areas of technical assistance most often stated are listed below, along with their rationale:

- Assisting both organizations in estimating the expected expenditures that the GOJ would incur by expanding access to the uninsured under alternative policy options (e.g., through universal coverage, or the incremental coverage of categorical groups of persons). No reliable estimates exist on the cost to the government of expanding CIP benefits to the uninsured. It is the role of the Higher Health Council's Technical Secretariat to provide such information to the government; however, both the Higher Health Council and the Health Insurance Directorate lack the necessary analytical capacity (in terms of personnel, computers, software, books and manuscripts) to provide such information,
- Assisting in the estimation of utilization rates and the identification of alternative cost-sharing options (e.g., co-payments, and premium contributions). Currently, insufficient knowledge exists on the appropriate cost-sharing for CIP beneficiaries (both existing and future enrollees). This is of import, given the recent MOH focus on "cost recovery" and "cost containment" policies. An effective strategy in either of these areas requires that the MOH understand those factors that effect utilization rates, such as variations in co-payment rates. Moreover, stakeholders emphasized the need for implementing an effective utilization review mechanism for CIP beneficiaries,³
- Assisting in the design and pricing of alternative benefits packages, and assisting in identifying alternative revenue sources (e.g., excise taxes) for funding alternative health insurance options. Stakeholders consistently cited the need for the establishment of a minimum benefits package for existing and future beneficiaries. They stressed the importance of designing benefits packages that are tailored to specific demographic groups. In addition, the rising cost of providing the current generous package of benefits to enrollees is viewed by many as been unsustainable.

The subject of health insurance reform has been a topic of discussion in Jordan, since the mid-1980s. However, with 40 percent of the population uninsured (1.9 million persons), increasing incidence of chronic ailments, rising health care costs, and significant out-of-pocket expenditures being incurred by households (JHUES, 2000), the current discourse suggest that monumental reform is inevitable. The need for building capacity within the Health Insurance Directorate, Ministry of Health and Higher Health Council, in the areas of health care economics, econometric analysis, health insurance benefits package design, and other areas indicated above is essential. Moreover, given that the Ministry of Health and the Health Insurance Directorate operate under separate budgets, the total costs of implementing policies that are formulated at the Central Ministry level may not coincide with the funds that are available at the Health

³ The three types of utilization review mechanism (prospective, concurrent and retrospective) do not exist for CIP beneficiaries. Hence, in an attempt to curtail the over-utilization of services, stakeholders stressed the importance of establishing such a structure in both the public sector. Limited utilization review does exist among some private sector payers.

Insurance Directorate.⁴ Therefore, a strategy needs to be developed whereby the Central Ministry better coordinates its policy design function with the Health Insurance Directorate, and the Health Insurance Directorate enhances its ability to project and negotiate its budgetary needs.

Proposed Activities April 2004 to October 2005

The PHR*plus* Assessment Team proposes to support the GOJ in the area of health insurance reform in the following ways:

- Developing Analytical Capacity: This will be achieved through extensive capacity building and on-the-job training (OJT) in the areas of data analysis, health care economics, statistical modeling and expenditure analysis. The focus of this training will be personnel within the Health Insurance Directorate, staff members of the Higher Health Council (Technical Secretariat), and selected members of the MOH Finance Department. Moreover, a significant data analysis infrastructure, in the form of computers and software, will have to be developed within both organizations,
- Health Insurance Benefits Package Design and Costing: Extensive capacity building in the areas of health insurance benefits package design and costing are needed within the Health Insurance Directorate and the Technical Secretariat of the Higher Health Council (Higher Health Council). Such capacity building will also include training in the costing of specific treatment categories (e.g., renal dialysis). Obtaining such information will assist policy makers in later estimating the burden of specific diseases, in the Jordanian society,
- Promote Ongoing Dialogue and Coordination: The Central Ministry and the Health Insurance Directorate must coordinate their efforts in policy design and implementation. Without such coordination of efforts, the government will be unable to estimate its capacity to expand and fund additional services to categorical groups of Jordanians, such as the uninsured. This coordination of efforts can be achieved by first convening a high-level meeting of stakeholders, in collaboration with the Higher Health Council. The purpose of such a meeting would be to highlight the various areas of policy priority to the government, as well as to highlight the need for inter-agency coordination in the formulation of health care policy,
- Estimation of Budgetary Needs: The Health Insurance Directorate lacks the capacity to accurately project its budgetary needs. This can be facilitated by developing an analytical capacity within the Directorate, trained in the proper use of budgetary simulation models that are based upon demographic, utilization and expenditure estimates,
- Continuation of the Health Insurance Pilot Project (HIPP): As stated by several stakeholders, the Health Insurance Directorate has gained a great deal from its participation in the HIPP. Full implementation of the activity, marked by the enrollment of

⁴ The MOH often designs policies, such as the expansion of access to categorical groups, which the Health Insurance Directorate is required to fund.

beneficiaries, should take place in April 2004. After that period *PHRplus* will assist in the monitoring and surveying of both beneficiaries and providers. That phase of the HIPP should require minor TA.

The activities outlined will require the selection of various experts to provide inputs of various sorts throughout the duration of the USAID 5-year strategy period. The initial inputs: building an analytical capacity within the Health Insurance Directorate, MOH and the Higher Health Council, capacity building in the area of benefits package design and costing, and the promotion of dialogue and coordination between the Central Ministry and the Health Insurance Directorate, can be provided during the 18 month period proposed in this document. This technical assistance would complement activities that are currently being conducted under the Health Insurance Pilot Project. In fact, the Implementation Unit can easily accommodate the additional computer hardware and personnel.

Proposed Counterparts: Higher Health Council (Technical Secretariat), Health Insurance Directorate, and MOH Finance and Accounting Department

GOJ Inputs: Support of participants in health insurance reform-related activities including salaries, travel, lodging, per-diem, approved work time to engage in activities that are related to this effort, support of *PHRplus* activities and active involvement.

Relevance to USAID/Jordan 2004-2009 Strategy: SR2, bullets 1, 2, 5, 6, and 7.

Short Term Technical Assistance

- STTA in econometric analysis (health care expenditure and utilization estimation)
 - STTA in health insurance benefits package design:
 - STTA for health insurance reform (promoting dialogue and inter-agency coordination):
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4. Hospital Decentralization Under New Strategy

Assessment Findings

PHR and PHR*plus* have provided technical assistance and capacity building, in the area of hospital decentralization, to the government of Jordan (GOJ) and the Ministry of Health (MOH) since March 1998. Earlier activities focused on educating stakeholders and others on the particulars of hospital decentralization, building capacity within pilot facilities, and updating the hospitals accounting and pharmaceutical inventory systems. Activities in the area of hospital decentralization have included the following:

- Oct 1998: National workshop held on implementing hospital decentralization in Jordan. This workshop included personnel from the private sector, central Ministry, Health Care Governorates, and all public hospital directors,
 - Apr 1999 to date: Established the Hospital Decentralization Steering Committee. This committee is tasked with overseeing the entirety of the decentralization activities in Jordan,
 - Apr 1999 to date: Princess Raya and Al Karak hospitals selected as pilot facilities. These institutions have and continue to receive extensive capacity building in the areas of accounting, finance, management, procurement, computer applications, English, and medical record keeping. Moreover, the organizational charts have been updated at each institution, and a Board of Directors has been nominated for each facility.
 - Oct 2000: Production of a document detailing the necessary policies and procedures that must be changed in order to achieve full implementation of hospital decentralization in Jordan. The document detailed the necessary Civil Service and Ministry of Finance rules that must be changed in order to facilitate long-term hospital decentralization.
 - Jun 2002: Conducting detailed cost studies at Princess Raya and Al Karak hospitals.
 - Aug 2002 to date: The design and implementation of a Management Accounting System for Hospitals (MASH). The MASH allows hospitals to track the flow of expenditures throughout the various departments of the hospitals, as well as assist hospital managers in setting managerial priorities, with respect to the distribution and allocation of hospital resources,
 - Oct 2002 to date: Established the Hospital Policy Forum, and continue to provide ongoing technical assistance to the Forum (held on a quarterly basis),
 - Jun 2003 to date: Implemented a pharmaceutical inventory software application, beginning at Al Karak hospitals and expanding to other pilot facilities,
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- Dec 2003:The development of job descriptions for all hospital personnel. Seventy-five distinct job descriptions were developed for personnel working at Al Karak hospital. The MOH has established a job description implementation committee that is tasked with implementing job description development at all MOH hospitals, using the Al Karak work as a template.

Current PHR*plus* technical assistance in the area of hospital decentralization has focused on building the technical and administrative capacities within the pilot hospitals, primarily Princess Raya and Al Karak hospitals. These hospitals have received extensive capacity building over the past 5-years in various areas related to hospital decentralization. Moreover, the two lead PHR*plus* counterparts for this activity, Dr. Abdel Razzaq S.H. Shaefi and Dr. Ayyoub A.K. As-Sayideh, have over the past 5-years developed the necessary skills, through extensive capacity building, that will enable them to lead future hospital decentralization activities, working with hospitals of similar size and missions to that of Princess Raya and Al Karak. In recognition of their training and accomplishments, the MOH has recently appointed them as Chief of Health Economics, and Chief of Strategic Planning, respectively.

The Assessment Team obtained information from several stakeholders, with respect to the hospital decentralization efforts. The hospital decentralization activity continues to receive strong support within the MOH. However, stakeholders repeatedly expressed their concerns that the activity is not rolling-out to other institutions at a fast enough rate. They overwhelmingly feel that modest gains have been made at the Princess Raya and Al Karak hospitals, and that the personnel within these institutions are now in the position to assist in facilitating an expansion of the hospital decentralization effort at hospitals of similar size and mission. Moreover, several stakeholders stressed the need to expand the hospital decentralization activity to Al Bashir hospitals, immediately. The reasons cited were the following:

- That Al Bashir hospital is the cornerstone of the MOH hospital system, and is in urgent need of policy intervention.
- That the MOH has learned a great deal from Princess Raya and Al Karak hospitals, and thereby is in a better position to use its trained personnel to facilitate implementation of decentralization at Al Bashir.
- That implementation of hospital decentralization at Al Bashir hospital would lead to a rapid adoption of this policy at other facilities, given its prominence in the public hospital system. For example, Al Bashir hospital is the facility where the Chiefs of the various medical departments, of all MOH hospitals, are located.

The subject of implementing hospital decentralization at Al Bashir hospital has been a topic of discussion since April 1999. During that period, the MOH hospital decentralization Implementation Committee considered Al Bashir hospital, due to its size and complexity, not to be an appropriate facility to pilot such an activity. Since that time, several managerial and administrative changes have taken place within Al Bashir. These changes make implementation less challenging than it would have been in 1999. In addition, the MOH has learned a great deal more about hospital decentralization, over the past 5 years, and now has sufficiently

trained personnel that are able to carry out the day-to-day technical aspects of this work. Hence, it is the Team's assessment that hospital decentralization activity be expanded to include Al Bashir hospital, as part of a larger more concentrated effort in hospital accreditation. In other words, the Team agrees with the assessment that Al Bashir is a "special" hospital within the MOH network of facilities. Therefore, the intervention required for this facility will require more specialized and focused intervention than that which occurs under the hospital decentralization activity alone. It is of import that hospital decentralization and hospital accreditation be simultaneous interventions, with respect to Al Bashir hospital.

Proposed Activities April 2004 to October 2005

The PHR*plus* Assessment Team proposes to support the GOJ in the area of hospital decentralization in the following ways:

- The MOH should include Al Bashir hospital as part of its decentralization effort, preferably within the framework of a broader plan of implementing hospital accreditation. Due to the size and complexities of this institution, Al Bashir hospital requires a concerted and highly technical intervention – something beyond the scope of the current decentralization effort.
 - The hospital decentralization activity should be expanded beyond the four pilot facilities. Drs. Ayyoub and Abdel Razzaq should focus their attentions on coordinating personnel at Al Karak and Princess Raya hospitals, for policy intervention at similarly sized hospitals. For example, a significant amount of work remains to be done at Al Nadeem and Jerash hospitals, in the areas of capacity building and OJT. Drs. Ayyoub and Abdel Razzaq should take the lead in designing work plans for capacity building at these two institutions, using personnel from Al Karak and Princess Raya as trainers. The PHR*plus* project should facilitate such efforts, however, the MOH must take the lead in implementation.
 - PHR*plus* should continue to provide targeted technical assistance in the implementation of the Management Accounting System for Hospitals (MASH) and pharmaceutical inventory application at Princess Raya and Al Karak hospitals. Personnel trained at these institutions can then serve as trainers of personnel at other hospitals.
 - PHR*plus* should continue to play an active role in the decentralization effort; however, the role would be that of a facilitator of all training activities (e.g., finance, medical records, accounting, procurement), and the source of targeted technical assistance, such as the implementation and training of personnel in MASH applications.
 - PHR*plus* should assist the Chief of Health Economics and the Chief of Strategic Planning in identifying the appropriate skill levels of the MOH personnel that will work under their direction. However, it is their responsibilities to organize, supervise, monitor and provide OJT to their staff, throughout the implementation process. In other words, the MOH is now in a position to oversee and coordinate the expansion of the hospital decentralization effort.
 - PHR*plus* should continue to provide technical assistance to the *Public Hospital Policy Forum*.
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The proposed assistance to hospitals, under the hospital decentralization effort, would also contribute to any newly implemented hospital accreditation in Jordan. It is proposed that *PHRplus* identify expert consultants in MASH applications, and hospital management. The experts, in collaboration with *PHRplus* counterparts, will work with the accounting and finance personnel from each hospital.

Proposed Counterparts: Chief of Health Economics and Chief of Strategic Planning in MOH

GOJ Inputs: Support of participants in the hospital decentralization effort, including salaries, travel, lodging, per-diem, approved work time to engage in activities that are related to this effort, support of *PHRplus* activities and active involvement. In addition, the Chief of Health Economics and Chief of Strategic Planning within the MOH should take leading roles in rolling-out the decentralization effort to hospitals, that are of similar size and mission to Princess Raya and Al Karak.

Relevance to USAID/Jordan 2004-2009 Strategy: SR2, bullets 2, 3, 4 and 9

Short Term Technical Assistance:

- STTA in Management Accounting System for Hospitals (MASH)
 - STTA in MASH software system updates
 - STTA in management consulting
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5. Hospital Accreditation Under New Strategy

Assessment Findings

The Assessment Team obtained feedback from several stakeholders about the need for establishing a hospital accreditation program in Jordan. Several reasons were cited; the most prominent were the following:

- The need to improve the quality of hospital care in both the public and private sectors.
- The need to enhance the efficiency in which services are produced and delivered.
- As a quality indicator, that will attract hospital clients from neighboring countries.
- As an eligibility criteria for private sector hospitals that are seeking public sector contracts.
- To bring Jordan's public and private hospital, in line with the level and quality of hospital services that are produced in developed countries.

This activity is proposed as a new element of the PHRplus project in Jordan, although PHRplus has contributed in the past to the policy dialogue on this subject, including briefings to the Ministry of Health (e.g., August 2000 to the national private sector regulatory committee and 2003 to the Quality Assurance Directorate at Al Bashir Hospital), and concept papers (e.g., February 2002 for the Director of Planning and Projects).

The subject of hospital accreditation in Jordan has been discussed since at least the mid-1980s, including the appointment of a hospital accreditation committee in 1987, which was later dissolved. The recognition of the need for accreditation has been building since then, and has intensified in recent years. In the past year, the Higher Health Council (HHC) has been activated and has focused largely on the issue of accreditation. A subcommittee of the HHC has been formed to address this issue, and WHO has agreed to support the subcommittee by providing a technical expert to provide 3 consultations over a 2-year period.

There is precedence for accreditation in Jordan, including the existence of an Accreditation Council of the Higher Education Council, as well as the recent development of a basis for accreditation of MOH health centers by the MOH Quality Improvement Directorate supported by the PHCI project. These in-country accreditation initiatives combined with models of hospital accreditation in the region and internationally can be examined as Jordan moves toward the establishment of a hospital accreditation program.

Proposed Activities April 2004 to October 2005

The PHRplus Assessment Team proposes a 2-pronged activity to support the development of a solid hospital accreditation program for Jordan: assistance to the GOJ in developing the accreditation process and program; and assistance to hospitals in preparing for the accreditation process.

Component 1:

The first prong is to provide technical assistance and capacity building for the HHC in the development of a Jordan-specific accreditation program and process. This activity would entail the selection of various experts to provide inputs of different sorts over the entire life of the USAID 5-year strategy period. The initial inputs would be provided during the 18-month period proposed in this document. The TA would complement that to be provided by WHO and would focus on the initial steps of policy and program development, including assistance in establishing the purpose, placement, governance, processes and structure for the program. Initial steps would also be taken in the development of standards and assessment instruments, including decisions on which model(s) of accreditation to adapt, or whether to develop entirely new standards. In order to insure that instruments conform to internationally recognized standards of practice for the assessment process itself⁵ it is anticipated that the development and testing of the survey instrument for reliability and validity would be a multi-year process. Other steps in the process beyond the initial 18-month period would include institutionalization of the program and development of staff and consultants (surveyors) to guarantee the ability of the program to provide continual re-accreditation of hospitals.

Proposed counterparts: Higher Health Council and other accreditation bodies as established

PHRplus Inputs: STTA from accreditation specialists

GOJ Inputs: Support of participants in accreditation-related activities including salary, travel, lodging, per-diem, resource materials, approved work time to engage in activities related to accreditation within their institutions, out-side of the formal conference and training settings; support of PHRplus activities and active involvement.

Relevance to USAID/Jordan 2004-2009 Strategy: SR2, bullets 1, 2, and 3

⁵ Such as described in the "Standards for the Accreditation of Certification Programs," National Commission for Certifying Agencies, US National Organization for Competency Assurance, 2003.

Component 2:

The second prong in the proposed accreditation assistance is to provide support to Al Bashir and other selected hospitals in preparation for the accreditation process. Assessment Team discussions with the leadership of both public and private hospitals revealed a growing understanding of the importance of the accreditation process in assuring quality and ultimately the sustainability of individual hospitals, as well as of the hospital sector in Jordan. This component is also complementary to the ongoing PHRplus assistance in hospital decentralization. The proposed assistance to hospitals would also contribute to the continuing momentum and support for accreditation within the hospital sector. The assistance to hospitals proposed for the 18-month PHR*plus* work plan period is intensive, but would result in very concrete outcomes within the plan period.

It is proposed that PHRplus identify expert consultants with experience working in hospitals preparing for the accreditation process (and when possible also experience as surveyors), to work with each hospital department to develop or revise policies and procedures and implement actions to insure compliance with generally accepted (and eventually, locally established) standards and practices. Each departmental consultant would work intensively with the appropriate departmental leadership and staff at Al Bashir Hospital to achieve agreed objectives. In addition, each external consultant would provide training for departmental staff of selected public and private hospitals, to be followed by facility-level consultation by local consultants (PHR*plus* staff and/or counterparts) to implement accreditation preparation activities within each department of the selected hospitals.

PHR*plus* proposes to offer this department-by-department training to 5 public and 5 private (non-profit and for-profit) hospitals, to be selected on the basis of applications by hospitals and selection criteria to include commitment of the hospital leadership to support staff involvement in periodic training programs in Amman, as well as on-site activities required to prepare departments for accreditation. Eligibility criteria for participation would include evidence of training budget available to support staff participation, and willingness and ability of hospitals to invest in additional equipment, staff, and supplies needed to bring each department up to standard.

Counterparts: Al Bashir Hospital and 9 other hospitals to be competitively selected for participation (public hospitals would ideally include hospitals participating in PHRplus decentralization activities).

PHRplus Inputs: departmental consultants; hospital accreditation consultants; and other categories of consultants as determined by project need and work plan

GOJ Inputs: Support of participants in accreditation-related activities including salary, travel, lodging, per-diem, resource materials, approved work time to engage in activities related to accreditation within their institutions, out-side of the formal conference and training settings; support of PHRplus activities and active involvement.

Relevance to USAID/Jordan 2004-2009 Strategy: SR2, bullets 1, 2, and 3.

Short-term Technical Assistance

Component 1:

- STTA from accreditation specialists
 - STTA – 12 departmental consultants each for
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6. National Health Accounts Under New Strategy

Assessment Findings

PHR and PHRplus have provided technical assistance and capacity building to the GOJ and MOH in developing National Health Accounts since 1997. As a result, three NHA estimates have been produced, for 1998, 2000, and 2001. NHA capacity has been institutionalized within the MOH through the establishment of a permanent NHA Unit in the Directorate of Planning and Projects, which has been staffed with a Chief of National Health Accounts. However, the MOH has not fully staffed this unit with the three additional fulltime staff members (accountant, and two research assistants) that would allow for a fully functional unit. On-going and planned efforts include dissemination of 2000-2001 NHA results, including a national-level NHA dissemination workshop; development of an NHA summary brief for policy makers, in collaboration with JHU CCP; and development of a reproductive health NHA sub-analysis, in collaboration with POLICY.

Proposed activity April 2004 to October 2005

The Assessment Team proposes that the current NHA activities be completed as scheduled by September 2004. No additional NHA-specific inputs are required, other than inclusion of NHA personnel in continuing education opportunities as they arise.

Counterparts: MOH NHA Unit

PHRplus Inputs: Continuing support by PHRplus staff until September 2004.

Relevance to USAID/Jordan 2004-2008 Strategy: SR2, bullets 1, 2, and 6.

GOJ Inputs: Support of participants in the NHA activity, including salaries, travel, lodging, per-diem, approved work time to engage in activities that are related to this effort, support of PHRplus activities and active involvement. Take over activity completely after September 2004.

Short Term Technical Assistance

- Technical consultant for RH NHA
- Local consultants for RH NHA
 - Survey Supervisor
 - Data Collectors
 - Research Assistants

7. Cost Containment Under New Strategy

Assessment Findings

The Assessment Team obtained feedback from several stakeholders about the need for an effective cost containment strategy, to be implemented throughout the Jordanian health care sector. The reasons cited were quite similar to those often cited in countries with similar health care infrastructures, and population demographics. They included the following:

- Rising pharmaceutical expenditures in both the public and private sectors: Pharmaceutical expenditures represent 36 percent of total health care expenditures in Jordan. The vast majority of these purchases, 82 percent, occur within the private sector, due primarily to individuals' out-of-pocket expenditures.
 - Rising out-of-pocket expenditures on hospital services: In addition to rising out-of-pocket expenditures on pharmaceutical purchases, Jordanians also face rising out-of-pocket expenditures for the purchase of private sector hospital and physician services. This is due primarily to changes in technology, patients' expectations, and limited regulation of hospital and physician charges, as well as the absence of regulation in the area of technological adoption and diffusion.
 - Rising public sector expenditures on hospital, clinic, and other services: rising costs (or rising expenditures) in this sector are due to several factors: changes in population demographics; changes in the pattern of disease, from infections to chronic ailments; changes in health care technology; and changes in patients' expectations of the services they should receive from the public sector.
 - Large numbers of the uninsured seeking treatment at Ministry of Health facilities: Roughly 40 percent of Jordanians are uninsured. The vast majority of the uninsured receive highly subsidized services through MOH providers. Currently, the MOH does not have an effective "means-testing" system in place to determine the optimal cost-sharing rules for none MOH
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beneficiaries. Establishing such a system would allow the government to charge varying rates to different groups, based upon their household incomes and other factors. Moreover, based upon earlier PHR*plus* finding, the cost-sharing rules for MOH beneficiaries are at levels that are significantly lower than one might expect.

The reasons cited for implementing an effective cost-containment strategy in Jordan are supported by existing data, primarily data that has been compiled by PHR*plus*. However, prior to implementing an effective cost-containment strategy, it is imperative that stakeholders become more familiar with the causes of rising health care costs, as well as the possible interventions that might be undertaken by the government to contain such cost. The implementation of an effective cost-containment strategy requires a willingness on the part of consumers (patients) and providers (hospitals, clinics and physicians), to change their existing behavior, with respect to the utilization and provision of health care services. In this section we provide an overview of the issues, and the policies options that are available to the government. We then propose a series of activities, under PHR*plus*, aimed at assisting the government in the implementation of an effective cost containment strategy.

Cost Containment: Issues to be considered

There exist several methods for curbing rising health care costs in Jordan. However, each requires a change in behavior, as well as expectations, on the part of consumers (patients) and providers (physicians, hospitals, and clinics). Below we list several of the most commonly employed methods of cost-containment:

- **Public Hospital Cost Containment**: the most common methods for curbing rising hospital costs is through the implementation of an effective utilization review (UR) system or through the implementation of changes in hospital-based reimbursement methods. In Jordan, changes in hospital-based reimbursements are relevant for private sector hospitals, only;⁶ whereas, the implementation of an effective UR system can be applied to both public and private sector providers. There exists three types of utilization review (UR) systems that might be employed in Jordan, in public sector facilities:
 - **Prospective UR**: under such a system the MOH would implement a policy whereby patients and/or physicians would have to obtain prior authorization, from a public sector *utilization review authority (committee)*, prior to admission into a hospital setting. This would limit the number of unnecessary hospital admissions, an issue often raised by stakeholders. It must be noted that several private sector payers, such as Third-Party Administrators (TPAs), self-

⁶ The Government of Jordan (MOH) is both the financier and provider of public hospital services. Hospitals do not receive reimbursement for services rendered to CIP beneficiaries, their budgets are controlled central by the MOH.

insured firms and commercial health insurers have implemented similar utilization review policies, in an attempt to curtail their expenditures on hospital services.

- Concurrent UR: under such a system the MOH would implement a policy whereby MOH hospital *utilization review boards* would be established at all MOH hospitals. These boards would be tasked with performing a daily and ongoing assessment of the need for continuous hospitalization of patients. Patients' records would be assessed to determine the need for ongoing hospital-based treatment.
- Retrospective UR: retrospective utilization review occurs once a patient has been discharged from the hospitals. For the MOH, retrospective-UR and concurrent-UR can be combined to formulate an effective policy, whereby hospital-based *utilization review boards* can perform self-assessments of the hospital through a randomized sample of former patients' records. The board can thus determine if a pattern of over-utilization occurs in specific departments. Retrospective-UR is oftentimes utilized by private insurers to determine if penalties should be imposed on hospitals with unusually high, diagnostic-specific, lengths of stay.

- **Private Hospital Cost Containment**: the MOH may contain its expenditures on private hospitals services by changing the way in which it (via the Health Insurance Directorate) reimburses such hospitals for services rendered to Civil Insurance Program (CIP) beneficiaries. The MOH currently purchases slightly more than JD7 million (\$10 million) of services from private sector hospitals, per annum. The MOH reimburses these institutions on a fee-for-service basis. This method of reimbursement provides the greatest incentive for private hospitals to over charge the MOH for services rendered to CIP beneficiaries. Moreover, the MOH may further achieve its private hospital cost containment objectives through the implementation of an effective regulatory strategy. The typical areas of private hospital regulation are: technology (adoption and diffusion of technology in the marketplace); capital investment (limit new construction of private hospital facilities); service quality and service utilization. In Jordan, the most realistic areas of policy intervention, with respect to private sector regulation, are in the areas technological adoption and diffusion, and by limiting hospital capital investment. The regulation of service quality would require that the MOH obtain a significant amount of detailed information on hospital staffing, outcomes, and mortality statistics. Below we discuss the policy options that are available to the MOH, with respect to changes in reimbursement and regulatory strategies.

There exists two popular methods for containing rising hospital costs, by implementing changes in provider reimbursement:

- Implementation of a system of “flat-fee” reimbursement: under “flat-fee” reimbursement, the MOH would negotiate beforehand a fixed flat-fee for the treatment of categorical illnesses. This is in contrast to the current policy of paying for services on a charge-based (fee-for-service) basis. The latter utilizes the Jordan Medical Association and Private Hospital Association fee schedules on a procedure-specific basis (e.g., a separate charge for each intervention), while
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the former would provide reimbursement that is based upon a diagnostic-specific basis (e.g., a fixed amount for a hip replacement). This method of reimbursement would require the establishment of a system of diagnostic specific rates for MOH beneficiaries.

- Implementation of a system of “capitated” reimbursement: under a system of capitated reimbursement the MOH would reimburse private hospitals on a pre-negotiated per patient case (i.e., on a cost per patient basis). Under such a system, private hospitals would agree to provide an *array of hospital services* to MOH beneficiaries at a fixed rate per person. This method differs from the “flat-fee” method considerably. The “flat-fee” method is based upon the MOH negotiating a procedure-specific rate; while the “capitated” method would be based upon the provision of a “bundle of services” to the patient. It is this method of reimbursement that is currently being implemented under the Health Insurance Pilot Project (HIPP).

Below we list three of the most commonly employed methods for regulating hospital technology and capital investment:

- Implementation of Certificate of Need (CON) or similar laws: under such a system, private hospitals would be required to obtain MOH approval for new hospital investments that are above a certain threshold amount (e.g., JD100,000). This would include new capital investments for purchasing expensive equipment (such as Magnetic Resonance Imaging, MRI) or for expanding its physical structure. Implementation of such a policy would require that the MOH obtain and compile detailed information on private sector hospital planning and investment.
- Hospital Rate Regulation: under such a system, a government agency would review each hospital’s budget for the reasonableness of its cost increases. Hospitals that achieve targeted cost containment objectives would be rewarded with favorable reimbursement rates in the treatment of MOH patients. Such regulation requires a detailed review of the hospitals' costs and utilization data. In addition, the implementation of such a strategy would require that the MOH have personnel highly trained in statistics, accounting, finance, economics and hospital management.
- Cross-subsidization (via charitable care): the MOH can implement a system of cross-subsidization, whereby private hospitals are provided with tax incentives for providing a given amount of "charitable care" to indigent populations. This would require changes in GOJ tax laws, whereby an explicit hospital charitable code would have to be written into law. Under such a system, nonprofit hospitals would no longer automatically qualify for nonprofit status because of their affiliation with nonprofit charitable organizations;⁷ instead, the nonprofit hospitals' status would be determined by its adherence to an explicit nonprofit charitable statute that is written for hospitals exclusively. For example, nonprofit hospitals in the US are categorized as nonprofit based upon their tax exemption under the law, statute 501 (c) (3). Such

⁷ Nonprofit hospitals in Jordan are categorized as nonprofit due to their affiliation with a nonprofit charitable organization. Having the organization receive its charitable status in this way, does not assure nonprofit charitable behavior on the part of the hospitals. In order to effectively regulate and monitor such behavior, the GOJ should modify its tax laws such that the term "charitable care" is explicitly defined for hospitals that qualify for nonprofit tax exempt status.

hospitals are required to provide a given amount of charitable care, per annum, in order to maintain their tax exempt nonprofit status. No such law currently exists in Jordan.

- **Patient Focused Cost Containment Efforts:** a public or private sector cost containment effort cannot be successfully achieved in Jordan without the full participation of consumers (patients). Thus, in order to curb rising health care costs in Jordan, significant changes in consumers' behaviors and expectations must occur. There are at least three areas where such changes might occur:
 - Implementation of National Prevention Strategy: preventative measures must take place at both the individual and societal levels. At the individual level changes in lifestyle and dietary habits can yield significant cost savings over the long run. This becomes most apparent in the case of such preventable maladies as chronic bronchitis, coronary heart disease, hypertension, noninsulin-dependent diabetes mellitus, and lung cancer. Moreover, the Jordanian society is an extremely accident-prone society, with extraordinarily high rates of motor vehicle deaths and long-term injuries.
 - Changing Consumers' (patients') Expectations: for any utilization review (UR) program to be successful, the participation of patients is essential. In Jordan, as elsewhere, the initial implementation of UR policies is oftentimes marked by significant consumer resistance. In Jordan, patients are accustomed to being hospitalized for ailments that can be treated on an outpatient basis, as well as being hospitalized for extended periods of time. Accepting such policies will require significant education of patient education, as well as changes in their expectations.
 - Increasing Patient Cost Sharing (oftentimes called "cost recovery"): the MOH requires little to no cost sharing at the point of service, for both hospital and physician services. Once admitted into a hospital, a Civil Insurance Program (CIP) beneficiary is faced with zero co-payment amounts. Stakeholders often attribute the absence of effective cost sharing rules as a key reason for the over utilization of outpatient and inpatient services. The MOH should investigate the range of cost-sharing options that are available to it, for both CIP and non-CIP beneficiaries.

Proposed Activities from April 2004 to October 2005

The PHR*plus* Assessment Team proposes to support the Government of Jordan (GOJ), in the area of cost containment in the following ways:

- Assist in Developing a Rational Drug Strategy: the consumption of pharmaceuticals is highly unregulated in Jordan. Consumers may purchase an array of drugs through over-the-counter purchases. The MOH should consider the implementation of an effective prescription drug policy, one that requires the issuance of a bi-annually renewable prescription drug licenses for registered physicians. No such policy currently exists. Without such a policy, future policies aimed at
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controlling drug expenditures will be futile. Moreover, several stakeholders have suggested that the GOJ establish a national essential drug list, for providers and consumers. PHR*plus* can provide the necessary technical assistance for creating such a list; however, without the implementation of mandatory drug formularies at MOH hospitals and clinics, the establishment of such a list will not achieve targeted cost containment objectives.

- Implementation of an Effective Utilization Review (UR) Strategy: the over utilization of MOH facilities, both inpatient and outpatient, is pervasive. To affect changes in existing patterns of utilization, particularly at the hospital level, PHR*plus* proposes to assist the MOH in designing an effective UR strategy for its hospitals. This can be achieved by first establishing and educating utilization review committees at selected MOH hospitals. Technically, this can be viewed as a parallel activity to that of the proposed hospital accreditation activity. An additional activity that should take place is the educating of patient populations on the correct usage of MOH clinics and hospitals. Hence, a patient education campaign would be an essential aspect of PHR*plus* technical assistance.
 - Implementation of a Rational Policy of Private Sector Regulation: the private hospital sector in Jordan is highly unregulated. This has led to the rapid adoption and diffusion of hospital-based technologies, as well as the unregulated expansion of capital investments. PHR*plus* proposes to provide technical assistance in the following areas of private sector regulations:
 1. to conduct a feasibility study that focuses on the need, design, and implementation of an effective "Certificate of Need" type program in Jordan;
 2. to assist the GOJ in the design of an effective system of hospital cross-subsidization. The most feasible system would be one whereby the GOJ designs an explicit nonprofit charitable tax code for hospitals.
 - Assist the MOH in Designing Optimal Cost-sharing Rules: PHR*plus* proposes to assist the MOH in designing optimal cost-sharing rules for inpatient and outpatient services. Previous work that has been conducted by PHR*plus* and the Primary Health Care Initiative (PHCI) in the areas of hospital and clinic costing, can form the basis of such work. Moreover, PHR*plus* will assist the MOH in designing a system of means-testing; whereby patient populations can be identified based upon their "ability to pay". Effective cost-sharing rules must be designed such that patients of varying household incomes are required to pay different amounts. In other words, in order to assure equity in the distribution of services and equity in cost-sharing requirements, the MOH must first establish a system whereby patients with "less ability to pay" are required to share in less of their cost of treatment than patients with greater means.
 - Implementation of a National Preventative Strategy: PHR*plus* working with other projects (such as the PHCI and Johns Hopkins CCP) can assist the MOH in developing a national preventative health care strategy. Projects such as PHCI, with its primary health care focus, and Johns Hopkins CCP with its expertise in behavioral change communication, can collaborate in an attempt to design an optimal preventative health strategy. PHR*plus* can provide the necessary statistical expertise that will allow the MOH to estimate the cost savings that it would realize over the long-run through the implementation of such a strategy. For example, PHR*plus* can estimate the costs of illnesses that are due to smoking, and estimate for the government
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the savings that might result from a national campaign aimed at smoking cessation. Projects such as PHCI and Johns Hopkins can provide the necessary behavioral change information to the public in support of such a campaign.

- **Implementation of a Patient Communication Strategy:** PHR*plus* working with other projects (such as PHCI and Johns Hopkins CCP) can assist the MOH in effectively communicating with its beneficiaries, concerning the appropriate use of hospital and clinic facilities. As previously stated, patients oftentimes utilize hospital emergency room facilities for none emergency reasons. This can be remedied in several ways. First, through a national patient education campaign, aimed at assisting patients in the appropriate usage of hospital and clinic facilities. Second, by designing an effective referral system between clinics and hospitals. Third, by educating patients about any newly established utilization review programs, and their anticipated impacts. Finally, by changing clinic operating hours such that they coincide with the needs of local communities. In any event, PHR*plus*, working with the various Cooperating Agencies in Jordan, can assist the MOH in the development and implementation of such an effective patient communication strategy.

PHR*plus* Inputs:

- STTA in econometric (applied statistical analysis) analysis, most specifically expenditure and utilization estimations
- STTA in hospital management and the design and implementation of utilization review committees
- STTA in hospital regulatory policy
- STTA in pharmaceutical economics (pharmacoeconomics)

It should be noted that activities, such as the STTA in econometric analysis might overlap with the STTA that PHR*plus* proposes to provide under the health insurance TA; while the STTA in hospital management and the design and implementation of utilization review committees will overlap with technical assistance being proposed under the hospital accreditation and hospital decentralization activities.

GOJ Inputs: Support of participants in the cost-containment activity, to include salaries, travel, lodging, per-diem, approved work time to engage in activities that are related to this effort.

Relevance to USAID/Jordan 2004-2009 Strategy: SR2, bullets 1, 2, 3, 4, 6 and 9.

Short-Term Technical Assistance

- Econometric (applied statistical analysis) analysis and expenditure and utilization estimations
 - STTA in hospital management and the design and implementation of utilization review committees
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- STTA in hospital regulatory policy
- STTA in pharmaceutical economics (pharmacoeconomics)

Draft Assessment

Table 3: Summary of Technical Assistance Needed Under Revised PHR*plus* Work Plan, Based Upon Discussions With Key Stakeholders

Sector Issues and Problems Highlighted Through Interviews With Stakeholders	Programmatic Implications for PHR <i>plus</i>
<p>USAID/Jordan, MOH and other stakeholders clearly expressed an interest in implementation, and research that is focused solely on the design, implementation, and evaluation of high priority policy issues (e.g., the cost of providing MOH health insurance to categorical groups of the uninsured)</p>	<p>Areas of “research priority”, based upon the expressed needs of the MOH, should be factored into future PHR<i>plus</i> work plans. Currently, the project does not have a separate research component to support the current research needs of the MOH. The addition of such a component will require that the project keep abreast of areas of research priority to the government of Jordan, as well as the MOH. Hence, it is imperative that the project expands the scope of its counterpart base to include members of the Higher Health Council, as well.</p>
<p>Expanded need for health insurance Technical Assistance in the following areas:</p> <ul style="list-style-type: none"> • Estimating the number of categorical groups of the uninsured (e.g., children, aged, near-poor) • Estimating the health care utilization rates and needs of categorical groups of the uninsured • Estimating potential expenditures by the government for expanding access to categorical groups of the uninsured • Assisting in the design of a “minimum benefits package” for new and existing Civil Insurance Program (CIP) beneficiaries • Assisting in the development and design of alternative policy initiatives, in the area of health insurance reform (e.g., the establishment of a voluntary or compulsory health care system) • Assisting in the expansion of the Health Insurance Pilot Project, through the identification and evaluation of additional bundles of services to be contract out to private sector providers 	<p>The current Health Insurance Pilot Project (HIPP), based upon improving the MOH’s private-sector contracting abilities, should proceed until fully implemented (September 2004). PHR<i>plus</i> should continue to provide limited TA for the HIPP, which focuses primarily on the monitoring and evaluation of enrolled beneficiaries.</p> <p>If the HIPP is expanded, to include additional service categories, such TA should be viewed as an additional activity under the existing project.</p> <p>Expanding PHR<i>plus</i> health insurance technical assistance in the areas of estimating utilization and expenditure rates for alternative health care reform policies will require additional analytical infrastructure at the Health Insurance Directorate, as well as the Higher Health Council. Moreover, specialized training of personnel in econometric estimations and data analysis will have to take place, as part of the capacity building efforts.</p>

Table 3 (continued): Summary of Technical Assistance Needed Under Revised PHR*plus* Work Plan, Based Upon Discussions With Key Stakeholders

Sector Issues and Problems Highlighted Through Interviews With Stakeholders	Programmatic Implications for PHR <i>plus</i>
<p>Expansion of Hospital Decentralization Technical Assistance in the following areas:</p> <ul style="list-style-type: none"> • Inclusion of Al Bashir hospital in the decentralization activity • Continued work at Princess Raya, and Al Karak hospitals, using such facilities as focal points for the training of additional hospitals in the various areas of project intervention • Assisting in the development of a strategy for "rolling out" the decentralization activity to facilities in excess of Princess Raya, Al Karak, Al Nadeem and Jerash hospitals • Continued support for the Public Hospital Policy Forums, that are held quarterly 	<p>The inclusion of Al Bashir hospital within the hospital decentralization effort will require the development of a separate and specific work plan for this institution. One of the key features of the decentralization effort is the extensive training of personnel that will have to occur. Hence, PHR<i>plus</i> will have to significantly expand its training efforts under this component of the project. Moreover, over the past 5 years, PHR<i>plus</i> has trained a significant number of personnel at Al Karak and Princess Raya hospitals. These personnel can serve as trainers for personnel at Al Bashir and other hospitals.</p> <p>PHR<i>plus</i> role in the hospital decentralization effort should be viewed as being two fold:</p> <ul style="list-style-type: none"> • Firstly, as the facilitator of this activity. Currently, the MOH has two highly trained implementers of the hospital decentralization activity. These two individuals must take the lead responsibilities for carrying out the expansion of this activity. • Secondly, PHR<i>plus</i> should provide targeted TA and training in specific areas that are identified by the project.
<p>Inclusion of a Hospital Accreditation component to the PHR<i>plus</i> project, with Technical Assistance in the following areas:</p> <ul style="list-style-type: none"> • Educating hospitals (both public and private) on the various aspects of hospital accreditation • Assisting in the development of a "Hospital Accreditation Council" or similar body • Assistance in preparing selected hospitals for the accreditation process • Assistance in developing the various policies, procedures, instruments and indicators for implementing hospital accreditation in Jordan 	<p>PHR<i>plus</i> must use a two-pronged approach in providing TA in this area:</p> <ul style="list-style-type: none"> • Firstly, it is essential for the project to provide TA and capacity building for the Higher Health Council, in developing a Jordan-specific hospital accreditation program. • Secondly, technical assistance to prepare Al Bashir, and other selected hospitals, for the accreditation process. This proposed assistance will contribute to the momentum and support for hospital accreditation.

	<ul style="list-style-type: none">• PHR<i>plus</i> proposes to offer a department-by-department training to 5 public and 5 private hospitals (Al Bashir and the 9 other competitively selected hospitals)
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Table 3 (continued): Summary of Technical Assistance Needed Under Revised PHR*plus* Work Plan, Based Upon Discussions With Key Stakeholders

Sector Issues and Problems Highlighted Through Interviews With Stakeholders	Programmatic Implications for PHR <i>plus</i>
<p>Continued support of the National Health Accounts activity. PHR and PHR<i>plus</i> have been providing technical assistance and capacity building in NHA since March 1998. As a result, 3 NHA estimates have been produced: 1998, 2000 and 2001. The NHA activity has been institutionalized, as a permanent NHA unit within the Directorate of Planning and Projects and is now staffed with a Chief of National Health Accounts.</p> <p>Ongoing planned activities include:</p> <ul style="list-style-type: none"> • A national-level dissemination workshop • Development of a NHA policy brief, in collaboration with Johns Hopkins University CCP • A reproductive health NHA sub analysis, in collaboration with POLICY 	<p>The current NHA activities should be completed as scheduled by September 2004. No additional NHA-specific inputs are required, other than the inclusion of NHA personnel in continuing education opportunities, as they arise.</p>
<p>Inclusion of a Cost Containment component into the PHR<i>plus</i> project, with Technical Assistance in the following areas:</p> <ul style="list-style-type: none"> • Assisting in the development of a rational drug strategy • Implementation of an effective utilization review (UR) strategy for hospitals and clinics • Implementation of a rational policy of private sector regulation • Assisting in the design of optimal cost-sharing rules for CIP and none CIP beneficiaries • Assisting in the implementation of a national preventive health strategy, by providing the government with "cost of illness" estimations • Assisting in the implementation of a patient communication strategy that focuses on educating patients on the correct usage of hospital and clinic based services, as well as changes in utilization procedures and referrals 	<p>PHR<i>plus</i> role in the area of cost containment is as follows:</p> <ul style="list-style-type: none"> • Firstly, to assist the government of Jordan (GOJ) in designing and implementing optimal pharmaceutical regulatory policies, such as mandatory prescription drug licensing for physicians, the establishment of an "essential drug" list, and the design and implementation of mandatory drug formularies at selected MOH hospitals and clinics. • Secondly, assist in designing an effective utilization review (UR) policy, for selected MOH hospitals, to include the establishment of hospital-based UR committees • Thirdly, assist the GOJ in evaluating the need, design, and implementation of an effective "Certificate of Need" type policy for private hospitals. • Fourthly, to assist in the design and implementation of an effective system of hospital cross-subsidization, through changes in the Jordanian tax code, such it

	<p>provides for the explicit establishment of charitable none profit hospitals, such as the 501 (c) (3)</p> <ul style="list-style-type: none"> • Fifthly, assist the MOH in designing optimal cost-sharing rules for patient populations, as well as assisting it in the design and implementation of a system of hospital-based "means testing". <p>Finally, assist the GOJ in estimating the cost savings that may result through the implementation of effective preventative health strategies, such as tobacco cessation, and to assist in developing an optimal patient communication strategy.</p>
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Higher Health Council

Dr. Anwar Batiha, Secretary General

Dr. Jamal Abu Saif, Staff

Dr. Raghed Hadidi, Staff

Dr. Sanabel Barakat, Staff

Ministry of Health

Dr. Said Darwazeh, Minister

Dr. Sa'ad Kharabsheh, General Secretary

Dr. Ghassan Fakhoury, Assistant Secretary General for Planning and Development

Dr. Sami Al Duleimi, Assistant Secretary General for Health Directorates

Mr. Bassam Al Munaier, Assistant Secretary General for Finance

Dr. Ali As'ad, Assistant Secretary General for Health Care

Dr. Ismail Al Sa'di, Assistant Secretary General for Administration

Dr. Samir Al Kayed, Assistant Secretary General for Hospitals

Dr. Safa' Al Qsoos, Director of Quality Improvement Directorate

Dr. Mohammed Al Bataiyneh, Head of Childhood and Motherhood Services

Dr. Abdel Razzaq Al Shafe'i, Chief of Health Economics

Dr. Ayyoub As Sayaideh, Chief of Strategic Planning

Dr. Taissir Fardous, Chief of National Health Accounts

Dr. Riyadh Al Akoor, Director of Health Economics

Dr. Saleem Malkawi, Director, Yarmouk Hospital

Dr. Osama Samawi, Director, Al Bashir Hospital
Al Karak Hospital Staff

Health Insurance Directorate
Dr. Ma'moun Maghaiyreh, Director

Royal Medical Services
Major General Manaf Hijazi, Director

Academic Community
Dr. Musa Taha Ajlouni, Faculty, University of Jordan, Health Administration Department

Private Sector
Dr. Nasry Khoury, Director, Palestine Hospital
Dr. Mahmoud Al Taher, Director, Obstetrics Hospital, Head of Private Hospital's Assoc.

Donor Community
Dr. Hani Brosk, WHO

Contracting Community
Dr. Suleiman Farah, Johns Hopkins University, CCP Project
Dr. Basma Ishaqat, Policy Project, Futures
Dr. Carlos Cuellar, PHCI
Mary Segall, PHCI
Dr. Cal Wilson, PHCI
Dr. Ayman Mansour, PHCI
Michael Bernhart, CMS
Basim Azeez, CMS

The following list depicts the meetings conducted during each day of the evaluation visit:

<u>February 15 - Sunday</u>	
PHR <i>plus</i>	Dwayne Banks
PHCI	Carlos Cuellar
	Ayman Mansour
	Cal Wilson
	Carlos Carrazana
CMS	Michael Bernhart

MOH Mohammed Al Bataiyneh

February 16 – Monday

USAID USAID Staff
PHR*plus* PHR*plus* Staff
CCP Project CCP Staff

February 17 – Tuesday

Higher Health Council Higher Health Council Staff
RMS Manaf Hijazi and Administrative Staff
PHCI PHCI Senior Staff

February 18 – Wednesday

Palestine Hospital Nasry Khoury
Private Hosp. Assoc. Mahmoud Al Taher
Policy Project Policy Project Staff
MOH Sa'ad Kharabsheh

February 19 – Thursday

MOH Said Darwazeh
Sa'ad Kharabsheh
MOH Staff, Participating in Design of the Strategic Health Design

for health reform

February 20 – Friday

PHR*plus* Dwayne Banks
WHO Hani Brosk

February 21 – Saturday

PHR*plus* Dwayne Banks
MOH Osama Samawi

February 22 – Sunday

MOH Osama Samawi
PHR*plus* Dwayne Banks
CMS Basim Azeez

February 23 – Monday

Al Karak Hospital Al Karak Staff

USAID Debriefing
PHR*plus*

Assessment Team
Dwayne Banks

February 24 – Tuesday
MOH

Saleem Malkawi

Draft Assessment

Comparison: Original and Proposed CAP

Draft Assessment

Area	Original CAP Activity	Proposed CAP Activity
Health Insurance	Expand CIP capacity to contract for bundled health services, monitor such	Complete CIP capacity building to contract for bundled health services,

	contracts and reward good contract performance with the Health Insurance Directorate.	monitor such contracts and reward good contract performance with the Health Insurance Directorate. (Anticipated by April 2004)
	Contract private providers for bundles of reproductive health services with incentives for continuity and quality of care.	Monitor and Survey private providers for bundles of reproductive health services with incentives for continuity and quality of care after implementation by the HI Directorate (Anticipated after April 2004).
	Establish a sustainable mechanism to expand access to health care for the uninsured that addresses the organizational structure of public insurance, benefits, and financing.	Develop analytical capacity in the Health Insurance Directorate through on-the-job training in the areas of data analysis, health care economics, statistical modeling and expenditure analysis.
		Consult with the Health Insurance Directorate on the design of benefits packages and costing studies needed to cost-out various plans.
		Promote on-going consultation to the MOH and the Health Insurance Directorate in the coordination, policy design and implementation of health insurance.
		Assist the Health Insurance Directorate to accurately project its budgetary needs.
Hospital Autonomy	Establish a mechanism that enables MOH hospitals to share resources, technical strategies and knowledge to initiate and sustain MOH hospital improvements.	Complete a tool kit that enables MOH hospitals to share resources, technical strategies and knowledge to initiate and sustain MOH hospital improvements.
	Install and operationalize a cost accounting system in pilot MOH hospitals.	Provide consultation on a cost accounting system in Al Bashir Hospital.
	Design and implement new systems for identifying non-poor clients, accounting for fees collected, and strengthen financial controls.	Provide consultation on new systems for identifying non-poor clients, accounting for fees collected, and strengthen financial controls at Al

		Bashir Hospital.
	Design and implement a performance monitoring system for MOH hospitals.	Design and implement a performance monitoring system for Al Bashir Hospital as part of the Hospital Accreditation activities.
		Provide consultation to the MOH as the MOH rolls-out activities for decentralization of hospitals.
Accreditation		Provide technical assistance and capacity building for the HHC in the development of a Jordan-specific accreditation program and process.
		Provide support to Al Bashir Hospital and other selected hospitals in preparation for the accreditation process.
National Health Accounts	Establish and staff a NHA Unit in the MOH.	Completed
	Conduct a second round of NHA data collection and provide it to the MOH Planning Department.	Completed
	Improve the capacity of the MOH National Health Accounts team to independently manage the NHA process.	Provide support to MOH until September 2004.

Work Plan: Health Insurance Technical Assistance (April 2004- October 2006)

PROPOSED ACTIVITIES	Q1	Q2	Q3	Q4	Q5	Q6 October 2005	Q7	Q8	Q9	Q10	REMARKS
Developing Analytical Capacity Within Health Insurance Directorate, Higher Health Council, and MOH:											
1. Formal and OJT training in data analysis, to include basic statistics, SPSS software applications, and multivariate statistical analysis.											Work to be performed by PHRplus Staff, Short-term TA, and local universities. Training should include personnel from Higher Health Council (HHC), Health Insurance Directorate (HID), and MOH Finance and Accounting Section (MOH-F&A).
2. Formal and OJT training in health care economics, and expenditure analysis based upon utilization, demographics, and socioeconomic determinates of health care expenditures											Work to be performed by PHRplus Staff, Short-term TA, local and regional universities. Training should include personnel from HHC, HID, MOH-F&A.
Health Insurance Benefits Package Design and Costing											
1. Formal and OJT training in health insurance benefits package design and costing, to include Research Study Tour and/or Workshop to US institutions that specialize in providing such training											Work to be performed by U.S. based university and/or health policy centers. Training should include personnel from HHC, HID, MOH-F&A.
2. Workshop in Amman Jordan on estimating the "economic cost" of specific interventions (e.g., hip replacement), and introduction into the design of various Diagnostic Related Groups for Jordan											Work to be performed by PHRplus Short-term TA. Training should include personnel from HHC, HID, MOH-F&A.
3. Formal training in estimating the "cost of illness". This type of training will allow participants to better understand the methodology for estimating the "burden of disease" in Jordan											Work to be performed by PHRplus Short-term TA, may include training outside of Jordan as well. Training should include personnel from HHC, HID, MOH-F&A.

Work Plan (continued): Health Insurance Technical Assistance (April 2004- October 2006)

PROPOSED ACTIVITIES	Q1	Q2	Q3	Q4	Q5	Q6 October 2005	Q7	Q8	Q9	Q10	REMARKS
Promotion of Ongoing Dialogue and Coordination among HID and MOH											
1. Workshop on inter-agency coordination among public sector institutions											Work to be performed by PHRplus Short-term TA
2. Public policy assessment of the Health Insurance Directorate, the MOH and the Higher Health Council, with respect to inter-agency coordination in the design of health care policy											Work to be performed by PHRplus Staff and Short-term TA
Budgetary Estimation of the HID and MOH											
1. Training in the economics of budgetary estimations and simulations											Work to be performed by PHRplus Short-term TA. Training to include personnel from the HID, MOH-F&A
2. Design of MOH and HID microeconomic budgetary simulation models											Work and training to be performed by PHRplus Short-term TA. Training to include personnel from the HID, MOH-F&A

Work Plan: Hospital Decentralization Technical Assistance (April 2004- October 2006)

PROPOSED ACTIVITIES	Q1	Q2	Q3	Q4	Q5	Q6 October 2005	Q7	Q8	Q9	Q10	REMARKS
Al Bashir Hospital Decentralization											
1. Extensive training of hospital personnel in Management, Accounting, Procurement, Medical Records, Computer Applications, English, Customer Service and Public Relations											Work to be performed by PHRplus Short-term TA, and local universities. Training will be specifically designed for Al Bashir personnel, both OJT and formalized training.
2. Conduct hospital cost analysis of Al Bashir hospital											Work to be performed by PHRplus Staff and Drs. Abdel Razzaq and Ayyoub of the MOH.
Expansion of Hospital Decentralization Activity											
1. Assist MOH in designing its implementation plan for expanding hospital decentralization activity beyond Princess Raya, Al Karak, Al Nadeem and Jerash hospitals											Drs. Abdel Razzaq and Ayyoub of the MOH will take the lead in this effort, PHRplus will provide targeted technical assistance to facilitate this activity
2. On-the-Job and formal training in management, accounting, computer applications, English and medical records for personnel at newly established decentralization facilities. OJT Training to be based upon "training of trainers" model using personnel from Princess Raya and Al Karak hospitals											Drs. Abdel Razzaq and Ayyoub of the MOH will take the lead in designing the training curriculum and its implementation plan for both formal and OJT training activities. PHRplus will facilitate this effort by identifying the appropriate local training institutions, funding formal training, providing textbooks, writing utensils and the supplies that are needed for training activities
Implementation and Expansion of MASH Applications											
1. Training of selected hospital personnel in Management Accounting System for Hospitals (MASH) applications											PHRplus Short-term TA
2. Installation of MASH at selected MOH hospitals											PHRplus Short-term TA, and Drs. Abdel Razzaq and Ayyoub

Work Plan (continued): Hospital Decentralization Technical Assistance (April 2004- October 2006)

PROPOSED ACTIVITIES	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	REMARKS
Other Decentralization Activities											
1. Training of selected hospital personnel in pharmaceutical software applications											PHR _{plus} local consultant
2. Assist MOH Chief of Health Economics (Dr. Abdel Razzaq) and Chief of Strategic Planning (Dr. Ayyoub) in identifying the skill levels and personnel to work under their direction for expanding the hospital decentralization activity											PHR _{plus} staff working with Drs. Abdel Razzaq and Ayyoub
3. Continue to provide TA to the <i>Hospital Policy Forum</i>											PHR _{plus} staff and Short-term TA

Work Plan: Hospital Accreditation (April 2004- October 2006)

PROPOSED ACTIVITIES	Q1	Q2	Q3	Q4	Q5	Q6 October 2005	Q7	Q8	Q9	Q10	REMARKS
Hospital Accreditation: Component 1 (Establishing An Accreditation Infrastructure)											
1. Implementation of a national workshop on hospital accreditation in Jordan, to educate stakeholders about the systematic development of such a policy, and to clearly delineate expectations											PHRplus staff and Short-term TA. Participants will include invited members from both the public and private sectors. Private sector participants will include private sector hospital directors; public sector participants will include HHC, Senior Level MOH officials, Ministry of Industry and Trade.
2. Development of public and private sector National Hospital Accreditation Steering Committee, and plan of action for implementation.											PHRplus staff and local consultant. Members of this Steering Committee should consist of, at least, a representative number of Higher Health Council members. The Technical Secretariat of the Higher Health Council (HHC) will work closely with PHRplus in setting the agenda and task for this committee.
3. Development of the appropriate organizational structure, membership, and placement of the "National Accreditation Organization"											PHRplus, HHC, local consultant and Short-term TA
4. Assessment of the appropriate performance measurement system to be employed in Jordan for the accreditation process (i.e., the appropriate model of accreditation for Jordan)											PHRplus staff, Short-term TA, local consultant HHC
5. Development of the necessary performance indicators for Jordan, to be utilized as the official indicators to be employed with the performance measurement system											PHRplus staff, Short-term TA, local consultant, HHC, and team of local technical advisory panels will assist in the development of: a) clinical indicators, b) financial indicators, c) utilization and access indicators; and d) quality of care indicators

Work Plan (Continued): Hospital Accreditation (April 2004- October 2006)

PROPOSED ACTIVITIES	Q1	Q2	Q3	Q4	Q5	Q6 October 2005	Q7	Q8	Q9	Q10	REMARKS
6. Development of the various survey instruments to be design, based upon the performance measurement system and indicators developed											PHRplus Staff, Short-term TA, local consultant, HHC, and Hospital Accreditation Steering Committee
7. Development of standards, requirements, and number of surveyors needed to implement the various surveys											PHRplus Staff, Short-term TA, local consultant, HHC
8. Development of "accreditation certification" categories for Jordan, and guidelines for public information											PHRplus Staff, Short-term TA, local consultant, HHC
Hospital Accreditation: Component 2 (Preparing Pilot Facilities for Accreditation)											
1. Development of the selection process and the selection of 5 public and 5 private hospitals to serve as pilot institutions for the Hospital Accreditation program											PHRplus Staff, local consultant and HHC
2. Develop work plans for Al Bashir, and 9 other hospitals (5 private and 4 public) for the development of policies and procedures for selected departments											PHRplus Staff, local consultant, Short-term TA
3. Department by department training of hospital personnel on the establishment of policies and procedures, as well as an assessment of existing policies and procedures											PHRplus Staff, local consultant, Short-term TA

Work Plan (Continued): Hospital Accreditation (April 2004- October 2006)

PROPOSED ACTIVITIES	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	REMARKS
4. Develop Policies and procedures for selected hospitals											PHR <i>plus</i> Staff, local consultant, Short-term TA
5. Draft hospital-based standards and procedures to be agreed upon by Accreditation Steering Committee, for implementation											

SUMMARY OF HEALTH SECTOR REFORM TECHNICAL ASSISTANCE IN JORDAN (2004 to 2009)

Vision Statement for Health Sector Reform in Jordan: *To improve the relative efficiency by which health care services in Jordan are organized, managed and delivered, with the overall objective of improving the well-being and health care outcomes of its health care institutions and patients.*

Key Activities Under the New Strategy for PHRplus

- Health Insurance Reform (to include HIPP technical assistance)
- Hospital Accreditation
- Hospital Decentralization
- Cost Containment
- National Health Accounts

Overlapping Activities

- Cost Containment is a component (overlaps with) of Health Insurance Reform, Hospital Accreditation, and Hospital Decentralization
 - Pharmaceutical reform, to include work on establishing an essential drug list in Jordan overlaps with Health Insurance Reform, Hospital Accreditation and Hospital Decentralization
 - Specific activities for Al Bashir hospital overlap with Hospital Decentralization and Hospital Accreditation
-

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DRAFT SUMMARY OF HEALTH INSURANCE TECHNICAL ASSISTANCE (2004 to 2009)

OBJECTIVE: To increase health system efficiency and effectiveness by improving the analytical abilities of the Ministry of Health, Higher Health Council and Health Insurance Directorate, in the areas of private sector contracting and budgetary projections.			
Activity Summaries	Milestones (2004 to 2009)	PHR<i>plus</i> Contributions (2004 to 2005)	2009 Targets
1. Development of data analytical capacity with the Health Insurance Directorate (HID), Finance and Accounting Department of the MOH, and Technical Secretariat of Higher Health Council (HHC)	<ul style="list-style-type: none"> • Key personnel receive extensive training in the following areas: <ul style="list-style-type: none"> ○ SPSS programming ○ data analysis ○ statistical modeling ○ health economics ○ expenditure analysis ○ technical report writing 	<ul style="list-style-type: none"> • SPSS training of 10 to 15 key personnel • Training of 10 to 15 personnel in data analysis • Training of 15 to 20 personnel in health economics and policy analysis • Training of 15 to 20 personnel in expenditure analysis and its use for policy and planning 	<ul style="list-style-type: none"> • Key MOH, HID, HHC personnel are skilled at data entry, data analysis, and technical report writing • Key personnel are able to fully integrate health economics decision making into the policy process, with an emphasis on expenditure estimations based upon demographic changes
2. Health insurance benefits package design and costing, to include technical assistance for establishing an essential drug list in Jordan	<ul style="list-style-type: none"> • Key personnel receive extensive training in the following areas: <ul style="list-style-type: none"> ○ health insurance benefits package design ○ pharmacoeconomics ○ methods of cost analysis ○ cost-effective analysis ○ burden of disease methodology and estimations 	<ul style="list-style-type: none"> • training of 10 to 15 personnel in benefits package design • training of 10 to 15 personnel in cost analysis, and cost effectiveness analysis • training of 10 to 15 personnel in burden of disease methodology and estimations • provide research background that will lead to the establishment of an essential drug list in Jordan 	<ul style="list-style-type: none"> • Key personnel are able to design and update CIP benefits, based upon changing demographics and estimated needs • Key personnel are able to estimate the relative cost of specific health care interventions and their relative benefits to the nation • An essential drug list is developed for Jordan, and drug formularies are implemented at MOH hospitals and clinics
3. Estimation of budgetary needs	<ul style="list-style-type: none"> • Key personnel receive extensive training in the following areas: <ul style="list-style-type: none"> ○ managerial and accounting training in budgetary design ○ public finance ○ budgetary simulations 	<ul style="list-style-type: none"> • training of 10 to 15 personnel in managerial accounting and budgetary design and simulations • training of 10 to 15 personnel in public finance 	<ul style="list-style-type: none"> • Key personnel are able to better manage day-to-day accounting practices • Key personnel are more aware of public sector budgetary practices and budgetary estimation procedures

DRAFT SUMMARY OF HOSPITAL ACCREDITATION TECHNICAL ASSISTANCE (2004 to 2009)

OBJECTIVE: To establish nationally and internationally recognized standards, of providing hospital services to the Jordanian population, with the goal of enhancing the efficiency and quality to which services are provided to hospital patients in both the public and private sectors

Activity Summaries	Milestones (2004 to 2009)	PHR^{plus} Contributions (2004 to 2005)	2009 Targets
1. Development of a national awareness of the hospital accreditation process, its organizational structures (e.g., the Jordan Hospital Accreditation Commission), implementation and operational costs, as well as its policy implications for Jordanian hospitals, in both the public and private sectors	<ul style="list-style-type: none"> • Key stakeholders are aware of hospital accreditation, and its phases of implementation • Key stakeholders are aware of the costs of operating a hospital accreditation system • Key stakeholders have assisted in identifying, designing, and estimating the budgetary needs of establishing an "Hospital Accreditation Commission" in Jordan 	<ul style="list-style-type: none"> • Implementation of a national workshop, quarterly Accreditation Committee meetings, and the production of quarterly accreditation policy briefs • Training of key personnel that will manage the accreditation process in Jordan (e.g., HHC Accreditation Committee) • Study tour to the US based Joint Commission, the world premier accreditation organization 	<ul style="list-style-type: none"> • Key stakeholders are fully informed about the accreditation process, and trained to lead its implementation in Jordan • A Jordanian Hospital Accreditation Commission has been organized, staffed, trained and its sources of funding have been identified • The Accreditation Commission (Body) is able to enroll its first set of hospitals, beginning with the voluntary participation of 6 public or private sector facilities
2. Establishment of the performance measurement system to be utilized for the accreditation process	<ul style="list-style-type: none"> • Performance indicators are developed • A performance measurement system has been designed and adopted • Accreditation surveys have been developed, as well as their standards and procedures for implementation 	<ul style="list-style-type: none"> • Training of 25 key personnel on the design and implementation of performance indicators and performance measurement systems • Training of 15 to 20 key personnel on hospital accreditation survey design and implementation 	<ul style="list-style-type: none"> • Key personnel are able to design and implement a performance measurement system for Jordan • Key personnel in the HHC, MOH are able to design, and implement hospital accreditation surveys, as well as train additional personnel for this task as needed
3. Selection and preparation of pilot hospitals for voluntary participation in the accreditation process, to include Al Bashir hospital as one of the pilot facilities	<ul style="list-style-type: none"> • 6 pilot hospitals are selected for participation in the hospital accreditation process, and an assessment of their policies and procedures are conducted on 5 to 7 of their major departments 	<ul style="list-style-type: none"> • Selection of 3 public and 3 private pilot hospitals • Survey and assessment of existing policies and procedures at the 6 hospitals has been completed • Development of training plan for personnel at the 6 pilot hospitals, based upon the overall assessment 	<ul style="list-style-type: none"> • Pilot hospitals are able to estimate the total budget they will need in order to conform to the newly established performance standards, as determined by the Hospital Accreditation Body • Pilot hospitals apply for membership in the Jordanian Hospital Accreditation Commission

DRAFT SUMMARY OF HOSPITAL DECENTRALIZATION TECHNICAL ASSISTANCE (2004 to 2009)

OBJECTIVE: To improve the managerial, administrative and overall operational efficiency of MOH hospitals.			
Activity Summaries	Milestones (2004 to 2009)	PHR^{plus} Contributions (2004 to 2005)	2009 Targets
1. Al Bashir Hospital, targeted technical assistance in various areas of capacity building. This intervention will be conducted concurrently with the Hospital Accreditation intervention that Al Bashir Hospital will be a part of	<ul style="list-style-type: none"> Key personnel receive extensive training in the following areas: <ul style="list-style-type: none"> management accounting procurement medical records computer Applications English customer service public relations 	<ul style="list-style-type: none"> Management training for 35 to 40 key personnel Medical record training of 35 to 40 key personnel Customer service training of 50 to 60 key personnel Computer applications for 30 to 35 personnel 	<ul style="list-style-type: none"> Key personnel at Al Bashir Hospital have enhanced their on the job managerial skills Key personnel are more efficient at medical records keeping, and processing, and are able to train other employees in this area Customer service at Al Bashir is enhanced as determined by ongoing patient satisfaction surveys Relevant personnel are proficient in computer applications, English, and accounting
2. Detailed hospital cost study conducted at Al Bashir hospital	<ul style="list-style-type: none"> The total cost of producing hospital services at Al Bashir hospital is understood Policies and procedural changes are implemented as a result of the combined cost study information and Al Bashir's participation in the hospital accreditation TA 	<ul style="list-style-type: none"> Detailed cost study of Al Bashir hospital is conducted Recommendations for procedural and cost savings changes based upon cost study results 	<ul style="list-style-type: none"> MOH is fully aware of the cost of producing services at Al Bashir hospital and is using the study for projecting Al Bashir expenditures, in order to better budget for the facility's operation
3. Continued support for the current hospital decentralization effort, to include facilitating the selection of additional facilities for expansion of the activity. Also, expansion of the Management Accounting System for Hospitals (MASH) and the pharmaceutical inventory applications to additional facilities	<ul style="list-style-type: none"> Utilization Review (UR) Committees established at pilot hospitals, and an evaluation of their referral systems is conducted Revised MASH implemented at pilot facilities, with plans for expansion Facilitation of training activities at pilot hospitals, to include the "Training of Trainers" 	<ul style="list-style-type: none"> TA in the design and implementation of UR Committees Revision of MASH and its implementation at 5 to 7 hospitals Facilitation of training activities at the pilot hospitals, to include on-the-job training that is headed by MOH Trainers 	<ul style="list-style-type: none"> Pilot hospitals, and additional institutions, are better able to manage their patient flow, admissions, and lengths of stay Pilot hospitals are able to manage and track their budgets Hospital personnel trained in finance, accounting, medical records, management, computers